1.0 Description of the Procedure

Gender transformation is reconstructive surgery performed to correct an intersex state. An intersex state is a condition in which the appearance of the external genitalia is either ambiguous or at variance with the recipient's chromosomal or gonadal gender.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at http://www.dhhs.state.nc.us/dma/prov.htm.

3.0 When the Procedure is Covered

Gender transformation surgery is covered as reconstructive surgery when the congenital anomaly is discovered before two years of age or at the development of pronounced secondary sex characteristics during puberty.

4.0 When the Procedure is Not Covered

Gender transformation is not covered when the criteria listed in **Section 3.0** are not met.

5.0 Requirements for and Limitations on Coverage

Prior approval is required.

6.0 Providers Eligible to Bill for the Procedure

Physicians enrolled in the N.C. Medicaid program who perform this service may bill for this service.

7.0 Additional Requirements

Medical documentation that substantiates that the anomaly was present prior to the age of two, **OR** that the development of pronounced secondary sex characteristics occurred during puberty must be submitted with the prior approval request form along with a complete plan of care.

8.0 Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs.

8.1 Claim Type

Providers bill professional physician services on the CMS-1500 claim form.

8.2 Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes to the highest level of specificity that supports medical necessity.

8.3 Procedure Codes

CPT codes that describe the planned surgery should be billed.

8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

9.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1985

Revision Information:

Date	Section Updated	Change
1/01/04	Section 7.0	Added requirement for submission of plan of care with prior approval request.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.